TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
METROCREST SURGERY CENTERS

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-17-2102-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
MARCH 13, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2016 Texas Workers Comp Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $3,038.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the above captioned medical fee dispute resolution. We do not feel any additional is due. It is our position that the provider missed a step in their calculations."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2016	Ambulatory Surgical Care CPT Code 63650	$1,519.10	$0.00
	Ambulatory Surgical Care CPT Code 63650	$1,519.10	
TOTAL		$3,038.20	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - D00-Based on further review, no additional allowance is warranted.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to additional reimbursement for code 63650(X2)?

Findings

The requestor is seeking reimbursement for ambulatory surgical care services rendered to the claimant on March 22, 2016.

The requestor wrote "At this time we are requesting that this claim paid in accordance with the 2016 Texas Workers Comp Fee Schedule and Guidelines for Ambulatory Surgical Centers."

The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.

According to the explanation of benefits, the respondent paid $10,671.34 for code 63650(X2) based upon the fee schedule.

28 Texas Administrative Code §134.402(d) states, " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

28 Texas Administrative Code §134.402(f)(2) states "Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent; or (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the ASC service portion multiplied by 235 percent."

According to Addendum AA, CPT code 63650 is a device intensive procedure.

A. To determine the MAR for code 63650 is a five-step process:

1. **Step 1-Gather factors**:
   - According to Addendum B found on CMS website, the hospital outpatient prospective payment amount for code 63650 is $5,244.37.
   - The device dependent APC offset percentage found in Table 66 for National Hospital OPPS for code 63650for CY 2016 is 56.19%.
   - According to Addendum AA found on CMS website, CPT code 63650 has a Medicare ASC reimbursement of $3,993.90.
   - The Core Based Statistical Area (CBSA-City Wage Index) located on the White House/OMB website or CMS website for Carrollton, Texas is 0.9847.
2. **Step 2- To determine the device portion, you multiply the hospital outpatient prospective payment amount times the device dependent APC offset percentage**:

   $5,244.37 multiplied by 56.19% = $2,946.81.
3. **Step 3 - Find the geographically adjusted Medicare ASC reimbursement for code 63650. This step requires calculations**:

- The Medicare fully implemented ASC reimbursement rate of $3,993.90 is divided by 2 = $1,996.95.
- This number multiplied by the City Wage Index for Carrollton, TX $1,996.95 X 0.9847 = $1,966.40.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement $1,996.95 + $1,966.39= $3,963.34.

4. **Step 4- To determine the service portion:**
   - Subtract the device portion from the geographically adjusted Medicare ASC reimbursement $3,963.34 minus $2,946.81 = $1,016.53.
   - Multiply the service portion by the DWC payment adjustment factor of 235% $1,016.54 multiplied by 235% = $2,388.87
5. **Step 5-Add the service and device portion together to determine MAR**.
   $2,388.84 + $2,946.81 = $5,335.65.

The requestor billed for two units. Per Addendum AA, code 63650 is not subject to multiple procedure discounting; therefore, $5,335.68 X2 = $10,671.30. The respondent paid $10,671.34. The difference between amount paid and due is $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

Authorized Signature

		04/11/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.